



**Government of the
District of Columbia**

**An Assessment of the Health Services Delivery
System for Foster Care Children
In
the District of Columbia Child Welfare System**

**PREPARED BY
THE DISTRICT OF COLUMBIA CHILD AND FAMILY SERVICE AGENCY
OFFICE OF CLINICAL PRACTICE**



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I. Introduction

This report responds to Chapter VI, Implementation Strategy #6 of the *LaShawn v. Williams* Implementation Plan:

“CFSA will conduct an assessment of the capacity to provide health screening and physical and behavioral health evaluations for children in foster care, taking into account the DC Kids evaluation produced by the Court Monitor. From this assessment, CFSA will develop a plan of action and will propose provisions to the plaintiffs and the Court Monitor for incorporation into the Implementation Plan to assure that all children (1) receive a medical screening within 24 hours of entering the Department’s custody; (2) a full medical and dental examination within 30 days of entering physical custody; and (3) a thorough professional evaluation of his or her needs within 30 days of replacement.”

The report seeks to balance focused attention on the specific health care provisions required by the Implementation Plan (screenings within 24 hours, full examination within 30 days) with a broader description and assessment of the system, including the multiple publicly funded systems currently utilized by CFSA to obtain ongoing and routine health services for children in care. The reasons for the broader look at the health care system are that:

- ∞ A description of the full health care system for foster children in the District is essential for the work of CFSA and its partners as we seek, over the coming months, to strengthen services and achieve the outcomes required in the Implementation Plan. It is impossible to understand the system and identify useful next steps without at least a brief look at how all the parts fit together.
- ∞ In terms of outcomes for children, it is particularly problematic to look at screening and evaluations in isolation, since for these steps in the health care process to be effective, they must be linked appropriately to follow-up services.

In electing to complete an assessment of health care that addresses health services beyond those specifically required by the Court Ordered Implementation Plan (IP) - - screening within 24 hours, full examination within 30 days and a professional evaluation within 30 days of replacement - - **the District is not consenting to undertake any obligations relating to healthcare beyond those specified in the IP.** Rather, the District is looking at a broader range of issues in order to assist CFSA and cooperating agencies in their broader next steps.

A. Why A Specific Focus on Health Care for Foster Children?

According to the American Academy of Pediatrics, children in foster care have a higher incidence in the utilization of health care services due to their fragmented home life and various caretakers. They are, by definition, victims of abuse and/or neglect and may require extensive services. Children entering foster care are often in poor health due to multiple factors i.e., an adverse prenatal environment, parental depression or stress, drug exposure, malnutrition, neglect,

abuse, or physical or emotional trauma, any of which can negatively impact a child's subsequent development. Children in foster care also have higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays as well as poor school achievement.¹

In addition to the substantial need for health care services to foster children, jurisdictions around the country have found that delivering health care effectively to this population requires careful attention to both the individual functioning of the health care and child welfare systems and their interaction. As the reader will see, in national examples (reviewed for this report), certain features of the child welfare system and the health care system in different parts of the country make it difficult to achieve high quality health care for foster children. Some of these features include:

- ∞ The emergency nature of some removals, which may mean that children's health history and medical records are not available early in their foster care stay;
- ∞ The physical movement from neighborhood to neighborhood and the changes in caretaker that children experience in foster care, coupled with a health care system that may provide uneven access in different locations;
- ∞ The complexity of the health insurance systems and the potential that some needed care may not be covered or may be covered for some children but not others or by some providers and not others; and
- ∞ The limited availability of health care providers who have the expertise to provide the care needed by foster children as well as expertise in their specific needs and circumstances.

Successfully addressing these and other challenges is important not only to the well-being of children in foster care but also to the other core objectives of the child welfare system - - safety and permanence. First, a strong link between child welfare and health care is critical to well-informed decision-making during the initial investigation period, when the child welfare agency is assessing whether abuse or neglect has occurred and seeking to determine the right initial plan for the child. At this stage, health care information may be key to determining whether abuse or neglect has occurred, to understanding the overall ability of the birth family to nurture and care for the child, and to understanding special vulnerabilities or needs that the child may have. Second, after a child is in foster care, high quality physical and behavioral health services are key to supporting children in stable placements that may lead to permanence. The stable placement may mean enabling a child to go home promptly if that is possible or to become part of a permanent kin or adoptive family. If we are not able to provide effective and immediate mental health services that can address the trauma of abuse and neglect, however, then we risk having children move frequently among placements because foster parents and foster siblings cannot cope with their behavior. The result could lead to the worsening of the child's emotional health and greater difficulty in finding a permanent family for the child.

B. Objectives and Structure of This Report

When we initially designed this assessment, we identified three primary research objectives:

¹ American Academy of Pediatrics: Health Care of Young Children in Foster Care, 2002.

- ∞ To describe as fully as we could the actual delivery of health care services to foster children in the District of Columbia: what services do children receive, from which providers located in which jurisdictions, and funded by which funding sources?
- ∞ To assess the quality of services, drawing on generally recognized standards for care of children and adolescents and on criteria identified in the literature for health care services to foster children.
- ∞ To assess the specific measures in the Implementation Plan, developing benchmarks for the system's current performance.

As we moved into the collection and analysis of data, we found that the first task, description, was especially demanding because of the complexity of the system. Even though we began with what we thought was a good overall understanding of the key features of the health care system, we found that each time we looked at the details of payment, service delivery, or enrollment, we identified another nuance important to understanding the overall picture. In the end, we concluded that a careful description was itself an important contribution to the development of strong recommendations and next steps, and as a result, the bulk of this report provides what we believe is the first comprehensive description of the District's health care system for foster children. As indicated in Section II on methodology, the time limitations under which we were working for data collection and analysis has meant that the description is not yet as detailed as we hope it will be in the future. As indicated in Section VIII on action steps, we have now identified a range of data matches that we hope will give us more detailed information for the future.

Building on this description of our complex system, the report takes important first steps towards the assessment of quality, as laid out in the second and third research objectives above, and identifies the next steps required for a fuller evaluation. Section III of the report lays out the national context and highlights a set of broad criteria for quality that provide the background for the system description that follows. Section VII of the report draws on a number of sources of information to provide an early, initial assessment of strengths and weaknesses. Section VIII provides both immediate recommendations for action and recommendations for further data collection and analysis that will enable CFSA and its partners to take the next steps towards a high quality system of health care services for children in foster care.

C. Key Findings

This assessment allowed CFSA a snapshot of how physical and behavioral health care services are being delivered to children in the District of Columbia under its care. This process has helped staff to identify those areas where we are doing well as well as those areas where more work is needed to ensure better services to children and families. The key findings that we identified are:

1. The system for delivering health evaluations, assessments, and services to foster children in the District of Columbia is complex. Health and mental health services to foster children in the District are provided and supported by CFSA's DC KIDS contract, by Medicaid managed care organizations, by Fee For Service (FFS) Medicaid providers, by mental health providers linked to the District's MHRS community mental health system,

- by therapeutic foster care providers funded by CFSA, and by other providers supported by local dollars.
2. This is a moment of rapid change and reform for many of the agencies involved in health care for foster children.
 - ∞ Through the development and expansion of the Office of Clinical Practice (OCP) CFSA has added highly qualified and trained staff to ensure that the physical and mental/behavioral health needs of children in foster care are being met.
 - ∞ Rapid change and reform are taking place in the District's mental health system for children and families; a Family Treatment Court has been established; and Memoranda of Understanding between District agencies have been completed.
 3. Based on a data review and data match involving information from DC KIDS, CFSA's FACES system, and St. Ann's Infant and Maternity Home, an estimated 73% of CFSA children receive the required medical screen within 24 – 48 hours of placement².
 4. Many, but not all children, receive a full required Early Periodic Screening and Diagnosis Treatment (EPSDT) health and developmental assessment within 30 days. The complete data match to determine the percentage is expected to be completed by March 30, 2004.
 5. Strengths identified by this assessment in the District's system of health care to foster children include:
 - ∞ major investments in services by a range of District agencies, investments which appear to have paid off in an improved array of services for CFSA children and families;
 - ∞ a substantial array of community health care providers;
 - ∞ considerable investment in highly trained and qualified staff;
 - ∞ major reforms in process directed at improving coordination and continuity in the system;
 - ∞ work in progress to improve information collection and tracking; and
 - ∞ reduced social worker caseloads and improvements in practice which make possible an appropriate role for the social worker in supporting continuity in health care.
 6. Areas for further improvement identified by this assessment in the District's system of health care to foster children include:
 - ∞ system complexity leading to lack of clarity;
 - ∞ gaps in coordination of services, including incomplete enrollment in DC KIDS;
 - ∞ gaps in continuity of care, both while children are in care and prior to removal;
 - ∞ inconsistent availability of certain services within needed time limits;
 - ∞ incomplete enrollment of children in FFS Medicaid;
 - ∞ gaps in the management and monitoring of information, including difficulty in ensuring availability of medical record information at the initial screening.
 7. Systems across the county struggle with meeting identified goals and often have to make compromises in order to provide health care services to children.
 8. CFSA does not currently have a consistent policy or practice regarding getting consent for medications or changing medications for children.³
 9. The District is under more stringent timelines for providing initial medical screens and evaluations than other jurisdictions that are identified in this report.

² St. Ann's Infant and Maternity Home completes the combined EPSDT and initial medical screens within 48 hours of placement.

³ This is an area of further review and study.

II. Methodology

Major sources of information for this report included key informant interviews, document review, analysis of a range of administrative data from both internal and external sources, qualitative information from case reviews conducted by outside experts and from focus groups with foster parents, and case studies of experiences in other jurisdictions.

A. Key Informant Interviews

CFSA conducted key informant interviews with local and national individuals, stakeholders, programs, agencies and/or departments identified as having direct or relevant information that would guide and support the recommendations on health services for children in child welfare. The private providers who contract with CFSA and case manage 27% of the population as well as a focus group of foster parents were surveyed. Our sister agencies, the Medical Assistance Administration (MAA), the Department of Mental Health (DMH) as well as local organizations such as Children's National Medical Center (CNMC), Health Services for Children with Special Needs (HSCSN) and internal CFSA staff were interviewed. Jacksonville, Florida, Little Rock, Arkansas and Philadelphia, Pennsylvania systems were examined. A complete list of interviewed individuals is included in Appendix A of this document.

B. Document Review

CFSA also reviewed available financial, program and statistical reports and related documents for relevant services. We analyzed invoices that were submitted by contractors in relationship to funding streams. CFSA synthesized and summarized the information from all applicable sources to develop the recommendations contained in the conclusion of this report. A list of documents/reports reviewed is included in Appendix B of this document.

C. Administrative Data

CFSA also analyzed a substantial amount of administrative data in order to gain a clearer picture of the children and families being served, the services offered to them, and the nature of the provider network. Key sources of information were CFSA's FACES system and the data system operated by DC KIDS, as well as data from HSCSN and data recorded by the OCP as part of its function of tracking referrals for evaluation and services. As indicated below in the discussion of data limitations, we believe there is a great deal more that we can learn from these administrative data sources and hope to mine them further in the future.

D. Qualitative Data

In order to get an initial sense of the experiences that children, caregivers, social workers, and others have with the health care system, we took advantage of several available sources of information. First, we reviewed both the overall findings and the detailed case stories developed by the team of outside experts (with CFSA staff) who conducted a Qualitative Services Review (QSR) at CFSA this past October. The reviewers looked at a sample of approximately 40 cases and conducted an intensive look at the quality of services (including health care) and the outcomes for children (safety, permanence, and wellbeing), which included interviews with children, social workers, supervisors, service providers, foster parents, and others involved with the cases. Our review of this information was necessarily rapid, as the draft report was not available until late December. Second, we collected some information specific to health care as part of the broader focus groups conducted for CFSA's Needs Assessment. Health care questions were presented to eight foster parents in the focus group that centered around securing medical care services, barriers to accessing care, the availability of health information and how CFSA can better assist foster parents in meeting the child's medical needs.

E. National Case Studies

To provide context for our review of health care for foster children in the District, we identified three programs. The first two were programs identified by national experts (including CSSP, which identified Arkansas' PACE program as a model in its earlier review of the District's system) as particularly promising, and the third was a program in a jurisdiction whose setting is demographically similar to the District. Another program identified as providing promising practice was the Chadwick Children's Center in San Diego, CA, but in the time available, we were unable to collect sufficient information to complete a case study. Information on the programs was obtained mostly through interviewing, by telephone, an administrator or coordinator within the program in addition to consulting reports or Internet sites that highlighted or expanded on the initiative. Those interviewed were asked to give a description of the program, how it was funded, how the program linked to other service delivery systems and if outcome data could be shared with CFSA. Appendix A lists individuals who were interviewed. The perspectives presented here are largely those of staff who work directly for or with the program they were explaining.

F. Strengths and Limitations of the Methodology

A major strength of the methodology is its breadth. Rather than rely on a single source of information, we have explored a wide range of data sources with the potential of painting a rich and complete picture. In addition, having completed this broad scan of available information, we now understand more about what information is available and how we could mine it in more detail to answer specific questions. This extensive understanding is reflected in the next steps suggested in Section VIII below.

At the same time, we have not been able in the time available to explore individual data sources as intensively as we had initially hoped. For example, we were not able to complete data matches that would have shown us specifically what services CFSA children received in 2002

and 2003 from Medicaid providers and from DMH-certified providers. We were also not able to complete matches that might have shown us where CFSA children received care before being removed from their homes. We anticipate completing these data matches in the next stage of our work. For the qualitative data sources, we were able to gain an overview of the issues but, again, will need to use this overview as the starting point for more intensive follow-up in particular areas.

III. Health Care for Foster Children: The National Context

As we began our assessment of health care for foster children in the District, we found that we needed a national context in order to understand the range of options for constructing a strong system, the barriers to success, and the criteria that would enable us to assess where our system was succeeding and where it still needed to be shored up. As we looked around the country, several initiatives were identified as providing innovative and promising practices to the foster care population. Of these promising programs, we developed case studies on two: The Kids 'N Care Clinic at the Department of Health in Jacksonville, FL; and the Project for Adolescent and Child Evaluation (PACE) at the Department of Pediatrics at the University of Arkansas for Medical Sciences in Little Rock, Arkansas. As previously mentioned, we did seek information from the Chadwick Children's Center in San Diego, CA but were unable to collect the needed information in the time available. These programs provide a wide array of services to children who are in the child welfare system.

At the same time, we felt it helpful to review at least one example of another jurisdiction facing similar circumstances as the District: an urban, high-poverty, largely minority community. From a research perspective, we selected this program not to illustrate promising practices but to illustrate the range of options that cities are choosing to deal with the constraints and barriers that they experience in providing health care. The jurisdiction that we focused on was Philadelphia, PA, which serves a large, diverse inner-city population.

We sought to learn three things from these case studies:

- ∞ The range of options available for strong programs that provide health care to foster children;
- ∞ The barriers faced by all jurisdictions and the strategies, solutions, and trade-offs that they have chosen to meet these barriers; and
- ∞ The criteria or standards that could help us develop a framework to assess the quality of care provided by our system, now and in the future.

A. Kids N' Care and PACE: Promising Programs and the Choices They Have Made

Kids 'N Care Clinic – Jacksonville, FL

The Kids 'N Care Clinic in Jacksonville has been in operation for approximately one year. Services are provided by the Department of Health's Children's Medical Services Center. The Department of Health and the Department of Children and Families work closely to provide much needed health care screenings, an initial psychological assessment, dental referrals and other needed services to children who have been removed from their homes and will remain

under state supervision for a minimum of 72 hours. The purpose of the Kids 'N Care Clinic is to ensure that the children who come to the attention of the child welfare system a) are seen within 72 hours, as mandated by Florida law, b) receive regular and timely health care services and c) have current medical records that are accessible to health care professionals as well as caregivers. The Kids 'N Care Clinic sees between 220 and 260 children monthly.

When a child is removed from the home and a determination has been made that he or she will not return within the next 72 hours, the caseworker brings the child to the Kids 'N Care Clinic. The clinic is located in close proximity to the Children and Family Services for convenience. The staff that serve children who visit the clinic are provided by the Florida Department of Health, and funding for services is provided by Medicaid. The children who are seen by the doctors, nurses and nurse practitioners are given an EPSDT, a psychological assessment, dental referrals and referrals to other health or behavioral health needs as appropriate. If the child presents with more extensive needs than can be serviced by the Clinic, a CMS worker can report to the Clinic to assess the needs of the child and make the proper referrals.

In addition to the initial screening and referral services that are provided by the clinic, children are provided with on-going medical care. Children who are in out-of-home care, those who have been returned home from being in care as well as some children who are at-risk of maltreatment are seen by the staff of the Clinic for both well and sick visits. The on-going care allows for continuity in service provision to these children while under the supervision of the agency. It is not unusual for children in foster care to have multiple placements, but because there is continuing care provided at the Kids 'N Care Clinic these children will likely not have an interruption in their medical care. Caregivers who have custody of more than one child bring all of their children to one place for their appointments and staff make attempts to schedule appointments for different children in the same home close together for the convenience of the caregiver.

Staff report that some of the benefits of the Kids 'N Care Clinic are that the Kids 'N Care Clinic can serve all children who have come to the attention of the child welfare system. The services provided are tracked in an information system that follows the child and can be accessed and updated by Medicaid providers in other jurisdictions. The doctors who attend to the health care needs of these children also find that having current and accurate medical information for these children is an asset. Caregivers also find the Clinic useful because the information about the child's medical history is in a centralized location and if there is more than one child under the state's supervision in a home, all of the children can receive services through the Clinic. Other Medicaid providers who have received training from the Kids 'N Care Clinic staff can provide services to those children whose caregivers are located a significant distance from the Clinic. These "satellite providers" are able to enter information regarding the child's visit into the same database that the Kids 'N Care Clinic uses to keep the child's medical history up-to-date.

Although the Kids 'N Care Clinic is generally well received, there are several obstacles that staff, children and families have to overcome. Children who come to the attention of the child welfare system, whether or not they are removed, have often not been provided needed medical attention. Therefore, it is difficult for Clinic staff to compile medical histories because the child has not been to a doctor or because the doctor is not known and the child cannot provide the

information. Another obstacle occurs when workers, for various reasons, do not enroll the child in the correct Medicaid program. This causes confusion and, until the situation is rectified, children may not receive some services that would be provided if they had been enrolled correctly.

Project for Adolescent and Child Evaluation (PACE) Arkansas

The Division of Children and Family Services (DCFS) of Arkansas Department of Human services and the University of Arkansas for Medical Sciences (UAMS) collaborate to administer the Project for Adolescent and Child Evaluation (PACE). PACE provides comprehensive evaluations for approximately 170-175 foster children every month. There are sixteen (16) clinic sites across the state where evaluations take place, and children are seen at the site that is closest to their current placement. PACE is funded with Medicaid dollars and some general state revenues. PACE uses teams of developmental pediatricians, speech pathologists, psychologists or psychological evaluators and a secretary to administer services in each of the 16 sites. The assessment team typically sees four children in a day with the total time for each child's evaluation being between four and five hours. PACE does not provide the initial screening, but instead teams of doctors see foster children within the first 60 days of entering care, with the average at least 45 days. The initial placement screening occurs between 24 and 72 hours upon removal and is completed by another physician.

When a child is removed from his or her home, the DCFS health service worker is notified and then contacts PACE to schedule an appointment in the closest geographic area. The health worker forwards the child's name, date of birth and placement location to workers at PACE. A PACE worker then schedules an appointment at the site closest to the child's placement. Although social workers generally provide information in a timely manner, PACE workers get a weekly list of children who have entered foster care in order to compare the appointment list to the names of those children who are identified on the foster care list.

Before a child is seen at a clinic site, PACE workers have compiled as much of the child's history as possible. PACE workers contact the physician who completed the pre-placement screening, collect medical, behavioral and/or mental health records as well as school records; this information is also collected to avoid any duplication of testing or assessments. PACE workers copy all of the child's relevant information and pass it on to the Department of Children and Family Services to be added to the case file.

A PACE assessment includes a physical examination by a pediatrician; depending on the age of the child, a psychologist or psychological evaluator will administer tests for cognitive development, IQ, achievement, and behavior and emotional problems; and speech, language, hearing and vision tests administered by the speech pathologist. Following all of the assessments, the PACE team of doctors provides recommendations for follow up to the Department of Children and Family Services. This is accomplished by a PACE team member entering information directly into the child's record via the department's database. Immediately following the assessment, the team meets with the child's caseworker and foster parents, if they have attended the assessment, to review the testing and make recommendations for follow up care. The PACE team can also access the database to ascertain the outcome of the recommendations that were made. In terms of other types of follow-up, the PACE team sees the

child again three months after the initial visit to determine the child's wellbeing. The child is not seen again by the PACE team unless he or she leaves care and then returns after 6 months.

PACE has been serving the children and families in Arkansas for a long time, almost 10 years. However, the design of the health services delivery system does have some problems. First is the gap between the initial assessment and the screening done by the PACE team. The child's PCP completes the EPSDT, however if the child does not have a physician or has not seen a doctor in a long time it may be difficult in locating a doctor. As with the Kids 'N Care program, many children do not have medical records that can be easily accessed because they either have not been to a doctor recently or have moved so much that it is difficult to get an accurate medical profile. Another issue raised was the concern that some caseworkers do not see the value of recommended assessments or follow-up services.

B. Philadelphia: Shared Challenges and an Alternative Approach

Health Management Unit – Philadelphia, PA

HealthChoices is the name of Pennsylvania's waiver program to provide mandatory managed health care to Medical Assistance Recipients. HealthChoices is a system that allows a child in the child welfare system, who is eligible, to maintain his or her present physician. The Philadelphia Department of Human Services, which administers child welfare services, has created the Health Management Unit that allows social workers and support staff to attend to the physical health needs of children in care.

The Health Management Unit serves as a liaison between doctors and the managed care insurance providers to ensure that children receive appropriate health care. Workers in the Health Management Unit help foster parents and children navigate the healthcare system in Philadelphia so that there is a minimum of disruption of service. The Health Management workers also are the only people who can make changes to the health plan or the primary care physician of record. In addition, these workers begin the appeal process when an insurer denies a claim. This is done to ensure that the child's needs are met but also so that the Department of Human Services does not have to pay for services that should be covered by the managed care provider.

The Health Management Unit ensures that the HealthChoices system works correctly for the children in the system. HealthChoices allows those children who do come into the foster care system to maintain their current doctor and often the same managed care organization. When a child is removed from the home, the information on the child is passed to the Health Management Unit which compiles the child's information and makes arrangements for billing. The Health Management Unit does not have involvement in a case during the pre-screening. The prescreening is often not a medical exam; it can be just a statement from the investigating social worker that states the child seems healthy. The managed care organizations that provide services to the children in foster care are supported by Medicaid funding.

Although the Health Management Unit is successful in obtaining the needed services for children in foster care through HealthChoices as well as saving the Department of Human Resources money because of the ability to navigate the insurance and managed care process, there are some

obstacles that workers face. One such obstacle is, as with many new programs, there is a lack of understanding what services the Health Management Unit can provide. The social workers in the Health Management Unit do not carry a caseload, but serve as a liaison between the medical provider and the insurer. In addition, there is a broad-based attitude that managed care can not work. Another obstacle is related to how often children in the foster care system change placements and the lag time that can occur if a managed care provider must be changed and the child must go to fee for service in the interim. However, as foster parents continue to become more familiar with the services that are provided and how the Health Management Unit operates, it is believed that these obstacles can be overcome.

The Health Management Unit is also working toward implementing a health passport for children. The Passport program was piloted with 200 children with promising results. Children's information was documented and entered into a database that was maintained by a separate unit. The medical passport was used to maintain comprehensive medical information on a child that would be accessible to health care providers who saw the child.

C. Lessons Learned: Choices and Challenges

As suggested earlier, these brief descriptions offer useful hints about what is possible in the strongest jurisdictions as well as the barriers and trade-offs all jurisdictions face in designing health care for foster children. Six broad lessons stand out even from this broad-brush account:

1. Success is possible. With an intensive enough focus on staffing and special service delivery arrangements, it appears to be possible to overcome the barriers in order to:
 - ∞ provide assessments that are integrated across the different domains of health and mental health and responsive to the special needs of foster children (PACE, Jacksonville);
 - ∞ ensure continuity of care across multiple placements (Jacksonville);
 - ∞ ensure a complete and useful medical record while a child is in foster care (PACE, Jacksonville);
 - ∞ link assessments to services (Jacksonville);
 - ∞ provide assessments and services that appear seamless to caregivers and social workers and do not differ depending on funding source, insurance status, or home neighborhood (Jacksonville and PACE); and
 - ∞ meet standards of timeliness for screenings (Jacksonville) and assessments (PACE).
2. Successful systems appear to make trade-offs among many important goals, rather than succeed equally at all goals at once. For example, PACE does not provide screenings, and the potential gap between screenings and the in-depth assessment provided by PACE is identified as a challenge by the staff interviewed. PACE also does not link the screenings and assessments directly to follow-up care, although there are a number of mechanisms in place to hold social workers accountable for the follow-up. Jacksonville provides all assessments and services in one location, which could have an effect on accessibility for some families, and neither PACE nor Jacksonville appears to focus on continuity of care with the provider a child may have been seeing before entering care.

3. Program designs have different approaches to the right mix of service coordination vs. service delivery. In Jacksonville, the Kids 'N Care Clinic appears to deliver a wide range of services and potentially substitute, to some degree, for the regular network of health care providers. PACE provides high quality assessments, but for all other services, the social worker is to coordinate with the existing service delivery network. In Philadelphia, the Health Management Unit provides a coordination function but no service delivery, with the goal of enabling children to benefit fully from the existing network of providers.
4. Collaboration among systems is both a challenge and a characteristic of successful program designs. When asked to identify the major barriers to providing services, several people interviewed said that it was hard to get people to change from the old way of doing things. This includes workers, foster parents and other agencies. Although collaboration is important it is not something that comes naturally and because the child welfare system has the ultimate responsibility for the safety, well-being and permanency goals of children often the public agency must take the lead in brokering relationships
5. None of the systems has standards for timeliness as exacting as the District's. None of the systems appears to meet the Implementation Plan expectations of a screening within 24 hours and a full assessment within 30 days.
6. Even in strong systems, the situations of abused and neglected children pose major challenges. The example that comes across most strongly in these cases is the challenge of compiling a complete medical history. Because the medical history is unavailable at the time of removal or is hard to obtain even afterwards, the child welfare system must do what it can to ensure that from the time of removal forward, records are up to date and accessible to medical providers, subsequent foster homes, and schools etc.

The following matrix provides a side by side comparison of the three jurisdictions, based on staff reports of program design, accomplishments, and challenges:

	Jacksonville, FL (Kids 'N Care Clinic)	Arkansas (Project for Adolescent and Child Evaluation)	Philadelphia, PA (Health Management Unit)
<i>Initial Screening (D.C. must provide an initial screening within 24 hours of removal)</i>	Completed at the Clinic within 72 hours of removal from the home	PACE does not provide the initial screen, although one is occurs between 24 and 72 hours of removal	When possible the child's PCP completes the initial screening or a doctor that has been identified to do so
<i>Comprehensive Evaluation (D.C. must provide a full medical and dental within 30 days of entering care)</i>	Children receive an EPSDT, a psychological assessment, dental assessment and referral and referrals to other health or behavioral health professionals as needed	A comprehensive evaluation is completed within first 60 days of entering care. Evaluation includes: vision and hearing screenings, cognitive, academic, and behavioral/emotional assessments, medical/developmental evaluation, speech /language assessment, and feeding assessment when appropriate	
<i>On-going Care</i>	On-going health services are provided at the Clinic for all children who come to the attention of DCFS	DCFS health service workers are responsible for coordinating follow up care, not PACE workers. A PACE evaluator randomly selects a sample of 60 cases each month for review in to obtain verification from the health service worker about the status of the follow-up recommendation	The on-going health needs of the children in care are coordinated by the care giver and provided by the child's PCP
<i>Professional Evaluation & Replacement (D.C. must provide a professional evaluation to children within 30 days or replacement)</i>	No professional medical evaluation is given when a child changes placements	A professional medical evaluation only if the child has not been seen within the previous 6 months	It was not indicated that a child received a professional medical evaluation when he or she changed placements
<i>Effectiveness</i>	Staff report that caregivers generally find the services useful and		Workers report that the unit has saved the agency money because workers are able to work through the issues when insurers deny a claim
<i>Child and Adolescent Centered</i>	Clinical care is provided by board-certified physicians specializing in pediatrics and adolescent health	Care is provided by professionals who specialize in children's issues and the evaluations are age-appropriate	
<i>Accessible/Timely</i>	1)The clinic is in close proximity to the DCF offices so children are seen quickly when it is determined they will not return home w/in 72 hours 2) Children receive and initial screening within 72 hours and a comprehensive assessment in	With 16 clinic sites, an appointment is made for children at the site closest to their home and occurs within 45 days of removal from the home	Workers in the Health services unit are there to ensure that the needed services are accessible to foster children
<i>Efficient</i>	A caregiver who is caring for more than one child under DCF supervision can schedule appointments on the same day and bring all the children together	The health management unit that works with PACE gathers as much of the child's information as possible so that professionals do not duplicate procedures and have the most up to date information possible	The caseworkers are not responsible for working through the difficult issues that arise when dealing with insurance and health care providers, and can concentrate on their other responsibilities
<i>Continuity</i>	The clinic provides initial and on-going care for a child all in the same facility and information is stored a database for easy tracking and medical history retrieval	PACE professionals only see a child twice and makes recommendations, it is the responsibility of the case worker to ensure that the recommended services are provided	The children can often remain with their previous PCP who can provide referrals and other services as needed

D. Criteria for a Successful Health Care System for Foster Children

Looking at these case studies and other information about high quality health care systems, we sought to design an approach to assessment that would allow us to look in some detail at the strengths and weaknesses of the District's system. We developed a framework in two steps. First, we reviewed the criteria for health care delivery outlined by the Institute of Medicine (IOM) in its groundbreaking 2001 report "Crossing the Quality Chasm". This gave us a general framework for health care to children and adolescents. Second, we reviewed the case studies above and the April 2002 Center for the Study of Social Policy (CSSP) Evaluation of the DC KIDS program to come up with a fine-tuned version of these criteria that can help us consider care for foster children and adolescents in particular.

The framework that resulted from these two steps uses the IOM report criteria for general headings. In the interest of brevity, we have summarized the characteristics as follows:

Services for children and youth in care should be:

Safe—avoiding injuries to children and adolescents from the care that is intended to help them.

Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under use and overuse, respectively).

Child and Adolescent-centered—providing care that is respectful of and responsive to individual youth preferences, needs, and values and ensuring that youth and family values guide all clinical decisions.

Accessible/Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care.

Efficient—avoiding waste, including waste of public dollars, equipment, supplies, ideas, and energy.

Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Continuous – seamless and coordinated care characterized by integrated service planning and delivery through a consistent provider.

Before using these criteria to inform our assessment of the strengths and weaknesses of the District's health care system for foster children presented in Section VII below and the suggested next steps presented in Section VIII, the next task is to present the basic facts about the District's system and what it currently looks like. Sections IV, V, and VI carry out that task.

IV. Health Care for Foster Children in the District of Columbia: An Overview

This section provides the following: 1) a demographic description of the foster care population; 2) a description of the system developed by the District to assure that medical screens and physical and behavioral health evaluations are secured for foster care youth; and 3) a brief summary of the reforms currently underway in the District's health care systems.

A. Children and the Setting: Demographic Background

This section provides a snapshot of the children in foster care at CFSA on September 30, 2003. As illustrated in Table 1, of almost 3000 total children in care, 45 or 1.5% were infants under one year of age, more than 500 or 17% were preschoolers age 5 or under, about 2000 children or 68% were school age children ages 6 to 17, and 400 young people, or 14%, were young adults ages 18 to 21.

Table 1: Age

Age ranges	Number	Percentage
< 1 Years	45	1.51%
1-5 Years	518	17.36%
6-12 Years	1142	38.27%
13-15 Years	541	18.13%
16-17 Years	334	11.19%
18-21 Years	404	13.54%
<i>Total</i>	2984	100%

Table 2 reflects the virtually equal division of male and female youth: about 51% were male and 49% female.

Table 2: Gender

Gender	Number	Percentage
Male	1530	51.27%
Female	1454	48.73%
<i>Total</i>	2984	100%

Table 3 below provides information on the placement status of youth in care. Most of the children (about 2400 or 80%) live in family settings, either with kin or with non-kin foster parents. About 10% of the young people live in group homes and another 4% live in Independent Living settings and Residential Treatment Centers.

Table 3: Placement Type

Placement Type	Number	Percentage
Traditional	1115	37.4 %
Therapeutic & Specialized	580	19.4 %
Kinship	702	23.5 %
Group Homes/Congregate Care	288	9.56 %
Residential Treatment	133	4.46 %
Independent Living	126	4.22 %
Other	40	1.34 %
Total	2984	100 %

Table 4 below illustrates that on September 30, 2003, approximately 45% of the foster care children in CFSA custody during FY 2003 resided in the District of Columbia, 50% in the state of Maryland, and 5% in other jurisdictions. The number of children who live with families in Maryland, both kin and non-kin, is a result of many factors, including the close historic ties between the District and its suburbs and the nature of the housing market for families. Clearly, this pattern poses potentially complex issues for access to health care, along with other services.

Table 4: Locations

State	Number	Percentage
District of Columbia	1336	44.77 %
Ward 1	126	4.22 %
Ward 2	97	3.25 %
Ward 3	17	0.57 %
Ward 4	187	6.26 %
Ward 5	301	10.08 %
Ward 6	217	7.27 %
Ward 7	196	6.57 %
Ward 8	195	6.53 %
Maryland	1492	50 %
Other States	156	5.23 %
Total	2984	100 %

Approximately 27% of the children in custody were case managed by CFSA contract private provider agencies. Seventy-three percent (73%) of the children were case managed directly by CFSA, as illustrated in Table 5 below:

Table 5: Youth Case Managed by CFSA or Private Agencies

Case Manager	Number	Percentage
CFSA	2179	73.0%
Private Agencies	805	27.0%
<i>Total</i>	2984	100%

B. Overview of the District's Health Care System for Children in Foster Care

This section provides a brief overview of the multiple parts of the District's system of health services for children in foster care, intended to serve as a framework for the more detailed discussion in the next chapter.

First, foster children in the District, as in the fifty states, are eligible for Medicaid once they come into foster care by virtue of their status as foster children. Like many but not all jurisdictions nationally that are focused on the health care of foster children, the District of Columbia has chosen to make accessible health and behavioral services available through enrollment of foster children into a fee-for-service (FFS) Medicaid Plan. The purpose of a FFS Medicaid Plan is to enable children in foster care to have access to the full range of services required for their specific needs that often are more extensive than for other children. The majority of children in the District of Columbia before coming into foster care, are eligible for Medicaid as a result of low family income; the District's Medicaid Plan for these children covers them through Managed Care Organizations (MCO's).

In addition, the District has invested in a program to coordinate and provide service to this population with its specific medical and behavioral needs. This program, established by the CFSA during the *LaShawn* Receivership, is the DC KIDS program, currently located at CNMC. CFSA designed DC KIDS as the front door system to assure that health screenings and related evaluations are completed for each child who enters foster care. DC KIDS is CFSA's contract program through which comprehensive health care services for foster care youth are secured. The DC KIDS program was designed to provide initial medical screening, assessment services and coordination and linkage of youth to ongoing treatment services resulting from the initial screening and assessments.

As the detailed description below indicates, the original design of this program is not entirely consistent with its implementation. In practice, many children are not enrolled in or fully utilize the services in the DC KIDS program. In addition, the balance between DC KIDS' role as a coordinator of care and its role as a provider of care is not understood in a uniform way by everyone involved in the program.

Beyond screening and assessment, there are a number of routes by which children in care receive health care services and multiple sources of funding for these services. Children may receive services through the DC KIDS network, through their original MCO's, through FFS Medicaid providers, through the DMH Medicaid-funded network for behavioral health, through specialized foster care providers funded by CFSA to support children with greater medical or mental health

needs, or through locally funded service providers when services are not covered by Medicaid or are specifically ordered by judges of the Family Court.

In addition, there are currently a number of ways that the health and mental health service needs of children in foster care are identified and determined. The partners involved in determining what health care services children in foster care should receive include CFSA, the family, the caregiver, the clinical expert/ service provider, and the Family Court.

C. This Moment In Time: A System Undergoing Multiple Reforms

The system summarized above is currently experiencing multiple reform efforts, which are generally complementary in their goals and vision. The result is that no aspect of the system is standing still, making it hard to capture at any one point in time. Major reform efforts beyond CFSA's internal improvements include:

- ∞ As the DMH has worked to create a system of care for children and families in the District, the agency has also worked closely with CFSA and other District agencies to redesign services to children in foster care. Some of these initiatives include, but are not limited to:
 1. The development of a system of care for children at-risk of institutional care (residential care).
 2. The access of behavioral and mental health care by children through the certification of Core Service Agencies that are able to provide the continuity of care many of children in foster care require long after permanency has been achieved.
- ∞ The District has strengthened its linkages among the human services agencies that rely on Medicaid for important services, leading to a number of partnership initiatives. In particular, District agencies are working jointly to enhance Medicaid Reimbursement efforts for children in residential care as well as children in need of behavioral services.
- ∞ MAA is currently reviewing the service gaps (dental and visions) in fee for service network providers.

V. Health Care for Foster Children in the District of Columbia: The CFSA Role

A. CFSA Coordination: The Office of Clinical Practice

Prior to the year 2000, CFSA social workers were responsible for managing all aspects of services for their clients, including health care. A milestone was reached in 1999, when CFSA created and implemented a Health Services Unit. The first clinical staff member, a Registered Nurse, was appointed to oversee and develop its functions in 2000. However, in order to both comply with *LaShawn A. v. Williams* as well as meet the ambitious goal of a coordinated and expert directed services system for children served by CFSA, OCP was established. OCP's role encompasses both medical and behavioral components and to provide expert consultation about

health and behavioral needs of children to social workers, foster parents and other stakeholders. The OCP/Clinical Support/Health Services (CS/HS) divisions were established to serve as a gatekeeper and bridge to the medical and mental health communities for CFSA. The services of OCP are intended to support and assist the social worker, foster families and private agencies in navigating the health care delivery network. Staff include a pediatric physician, clinical psychologists, nurses, and clinical specialists at the LGSW and LICSW level of training.

The major functions of this team are as follows:

1. Coordinate and support services to children with medical and behavioral needs through consultation and linkages to existing service network that includes but is not limited to DC KIDS, DMH (Core Service Agencies), CFSA Contractors, FFS Medicaid providers and HSCSN.
2. Development, coordination and monitoring of services of CFSA contractors such as tutoring, mentoring, day care, nursing and therapeutic services.
3. Consultation, coordination and placement matching for children with complex medical and/or behavioral needs. These children are typically high-end need children often served within acute care hospitals, residential treatment centers, nursing homes, congregate care and treatment foster care.
4. Expert consultation in the design of an improved medical screen (FACES) to capture the critical information needed to maintain the current health care status of children in care.
5. The oversight, design, implementation and coordination of Facilitated Family Team Meetings that would engage a Multidisciplinary Team in decisions about placement and needed services for children entering or changing placements.

Examples of how these roles play out in practice include:

- ∞ Currently the Health Services Division nurses work closely with HSCSN in ensuring that children with medically complex situations as well as special needs are enrolled with HSCSN. We know that in FY03, 114 children in our care were enrolled with this MCO and their care is coordinated with our nurses. This is especially significant because they are our most fragile population. During the Hurricane Isabel in 2003, the nurses in OCP were able to ensure that all the necessary support was available to these children and that the foster parents had support and back up (i.e. shelter or respite at the Hospital for Sick Children)
- ∞ With the addition of the Pediatrician and Clinical Psychologist, the health and behavioral status of all children in residential care is reviewed more rigorously. There have been several examples where teams of nurses and OCP mental health specialists have been dispatched to residential treatment facilities to review the treatment and/or to resolve health/behavioral health issues.
- ∞ The recent enhancement of the FACES medical screens as described later in this document has established for the first time, an ability to monitor and review the health status of all children in care. This, coupled with the daily data exchange between DC KIDS and the agency, anticipated to begin shortly, will move CFSA significantly forward in assuring timely and appropriate services to children in care.

B. CFSA – DC KIDS Program

Program Design

The DC KIDS program was developed by CFSA and was implemented in October 1999. The program concept and design were based on a need for comprehensive health care services, which resulted from the *LaShawn A. v. Williams* decree and the agency's desire to provide high quality services. The contract was initially awarded to the District of Columbia Health & Hospital Public Benefit Corporation (PBC), where the coordination and provision of services occurred through the PBC community health centers and private pediatric medical and mental health providers. As a result of the closing of D.C. General's trauma center and hospital operated by the PBC, the DC KIDS contract was transitioned to CNMC on May 21, 2001.

DC KIDS is CFSA's contract program through which comprehensive health care services for foster care youth are secured. The DC KIDS program was designed to provide initial medical screening, assessment services and coordination and linkage of youth to ongoing treatment services resulting from the initial screening and assessments.

Children enter the program through initial assessments/medical screens. Upon completion of the initial medical screen, appointments are scheduled for Early Periodic Screening Diagnosis and Treatment (EPSDT)/comprehensive physical examinations for completion within 30 days. The EPSDT requirements include an unclothed physical examination, laboratory studies, behavioral health evaluations, dental and vision assessments. These services represent the core services that should be provided to all children in foster care utilizing the DC KIDS program. In addition to these services the DC KIDS program is responsible for re-screening all youth prior to a change in their placement.

The initial medical screens are to occur before the child's placement in an out-of-home setting designed to be accessible 24 hours a day. This assessment is used to identify health problems that require immediate attention. The EPSDT core services allow for a medical, behavioral, dental and vision baseline to be established for the development of a treatment plan for continuous routine and specialty care. All of the core services are necessary for establishing successful outcomes in permanency planning.

DC KIDS is intended to provide easy access to treatment services from primary, specialty and emergency health care providers. The Georgetown University Child Development Center Study⁴ indicates that youth entering foster care have higher rates of chronic medical, mental health and developmental problems. The DC KIDS program was designed to be CFSA's solution to meet the needs for this high-risk population. The program's target population included youth with a legal status of: a) shelter care; and/or b) committed⁵.

⁴ Meeting the Health Care Needs of Children in Foster Care; Georgetown University Child Development Center; September, 2002

⁵ The committed population that the DC KIDS program was designed to serve does not and did not include youth while in Residential Treatment Care.

The program was designed with the intent that services would be comprehensive and delivered in a timely fashion. Comprehensive health care refers to effective and integrated strategies and services for meeting the physical, developmental, mental, emotional, and dental needs. DC KIDS is expected to:

- ∞ Perform medical screens 24 hours a day, seven days a week;
- ∞ Conduct EPSDT assessments, i.e. comprehensive physicals;⁶
- ∞ Coordinate behavioral/mental health assessments;
- ∞ Arrange for specialty and emergency care;
- ∞ Coordinate care including transportation;
- ∞ Manage health care data and information;
- ∞ Collaborate among systems;
- ∞ Provide identified training and education;
- ∞ Exercise sensitivity to the cultural needs of CFSA youth and
- ∞ Provide clinical and administrative reports.

Chapter VII below on Findings lays out the data currently available regarding performance of the system, including DC KIDS and the other service providers taken together. It is important to note that the early information presented there suggests timely accomplishment of medical screening for the substantial majority of children and EPSDT assessments for many children. At the same time, however, a number of issues remain challenging; the goals set for the initial design were ambitious and have not all been met. Issues that remain challenging include:

Coordination of Service Providers

One of the primary responsibilities of the DC KIDS program is to coordinate and link youth to a network of providers for ongoing treatment services. In practice, DC KIDS uses linkages for some services, as illustrated by Table 7. However, for other services, the DC KIDS programs utilized CNMC⁷ exclusively, as illustrated in Table 6 below.

Enrollment of children in DC KIDS

Not all children in care are either enrolled or utilizing the services offered through DC KIDS. We are currently matching data to provide a better quantitative estimate of the extent of this issue. The overview is that CFSA's policy intent in regard to DC KIDS has been that all children in out-of-home care except for children served by the specialized MCO for children on SSI (HSCSN) should be enrolled. Although children in residential care are enrolled into the DC KIDS program health care services are delivered through the facility's provider network. However, for a number of reasons, not all children are in fact enrolled.

- ∞ Geographical barriers may play a part. With about half of CFSA children living in Maryland, it is possible that either foster parents or social workers find the care inconvenient.

⁶ Within 30 days of child entering care (IP) and on the periodicity schedule (MAA requirements).

⁷ Data was provided by CNMC for the DC KIDS program.

- ∞ There may be lack of clarity regarding the process for enrollment and the expectation that all social workers will carry it out.
- ∞ Social workers may believe that enrollment is optional and may recommend against enrollment if they believe that services will be delayed, if they are not sure that the child can remain connected to their previous physician while enrolled, or for some other reason.
- ∞ Roles and responsibilities among DC KIDS, CSFA, and other District agencies may need to be clarified.

Enrollment of Children in Fee-for-Service Medicaid

The District's policy is that children in foster care are enrolled in FFS Medicaid with access to the whole range of services they may need and coordination through DC KIDS. However, there are often delays in children's enrollment for a number of reasons, including process delays within CFSA as well as the reasons cited above. Children who are not promptly enrolled in FFS Medicaid generally remain enrolled in the MCO for which they were previously eligible, but that arrangement leads to a wide range of billing and payment complications and, in some cases, to extra financial costs for the District if local dollars are used to pay for additional services. We are currently analyzing data to provide a better estimate of the extent of delay.

Delays and Capacity Issues in Screening and Services

Another source that has contributed to our knowledge of health care delivery to children and youth in foster care is the recently completed CFSA Needs Assessment. As part of the Needs Assessment, focus groups were held. Separate sessions were held for foster parents (two group sessions), CFSA workers, consortium workers and Assistant Corporation Counsels (ACCs). Summaries from these focus groups identified the lack of quality mental health services as well as difficulty in accessing medical services, including dental services and orthodontia. Another issue that surfaced during the focus groups of foster parents and CFSA workers was that although the DC KIDS program was intended to streamline the referral process, in reality this process is cumbersome, lengthy and uninformed. Additionally, ACC staff and CFSA workers felt that this new system creates a backlog of requests and delays to service provision. One ACC stated the capacity of the DC KIDS system is too low to handle the demand for services to children and families. In addition to the Needs Assessment the QSR case stories also identified areas where there were delays in services. In one case, a child had not received therapy because the therapist was not in the DC Kids network, in another case the medical issues of one child who is in traditional foster care were being met, but his siblings who remained in the grandmother's care were not attended to in a timely manner.

Table 6 and 7 suggests that although a large number of EPSDT evaluations were completed by DC KIDS (EPSDT includes behavioral assessment components), there were 464 behavioral assessments, 184 dental services, 68 vision services and 105 developmental evaluations. It is not clear that these additional services were either part of the 30-day evaluations or resulting as recommendations from those evaluations. The data will be further refined and analyzed.

Table 6 also indicates 993 replacement screens were completed in FY02 that suggests based on preliminary analysis that medical screens were done in a majority of replacements. Preliminary CFSA placement data indicates approximately 1200 replacements per year.

Table 6: DC KIDS Services Provided to Foster Care Youth through CNMC in FY 2002

Service Category	# Unduplicated Youth Served	# Of providers delivering Service
Inpatient	40	1
EPSDT*	769	1
Medical/Legals*	51	1
Specialty Services	565	1
Placement Screens* – Initial Assessments	1533	1
Re-Placement Screens*	993	1
Neuro-psychiatric Assessments	17	1
Developmental Assessments*	105	1
Others: Child Protection	119	1

In FY 2002 DC KIDS utilized more than one provider for the following services, see Table 7 below:

Table 7: DC KIDS Services Provided to Foster Care Youth through Multiple Providers

Service Category	# Unduplicated Youth Served	# Of providers delivering Service
Dental*	184	4
Vision*	68	2
Behavioral Assessments*	464	4
Psychological Evaluations	87	3
Psychiatric Evaluations	228	5

*Denotes core services

C. Other CFSA-Provided Services

CFSA Local Spending on Health Related Services

In addition to DC KIDS, CFSA purchases some health and behavioral/mental health services with local dollars. As indicated in table 8, these are primarily behavioral and mental health services; however there are also medical and health related services included. During FY 2003 CFSA purchased medical and behavioral health related services totaling **\$3,428,537**.

Table 8: Medical Expenditures

FY	Service	Expenditure for the Year	Expenditure/Child/ Month
FY 2003	Anger Management	\$3,398	\$849.50
FY 2003	Audiology	\$1,017	\$508.50
FY 2003	Dental Services	\$39,603	\$649.23
FY 2003	Group Therapy	\$6,621	\$143.93
FY 2003	Individual Therapy	\$550,088	\$326.66
FY 2003	Medical Services	\$94,533	\$307.93
FY 2003	Medical Travel	\$2,108	\$234.22
FY 2003	Nursing Care	\$240,682	\$2,111.25
FY 2003	Occupational Therapy	\$3,555	\$237.00
FY 2003	One-On-One Care Continuing	\$1,236,117	\$1,630.76
FY 2003	One-On-One Care Emergency	\$124,358	\$4,288.21
FY 2003	Prescription Medication	\$58,598	\$121.07
FY 2003	Psychiatric Services	\$53,002	\$546.41
FY 2003	Psychological Day Program	\$75	\$75.00
FY 2003	Psychological Services	\$497,566	\$440.32
FY 2003	Psychotherapy (Other)	\$60,597	\$582.66
FY 2003	Psychiatric Services	\$3,550	\$208.82
FY 2003	Substance Abuse Services In-Patient	\$452,469	\$5,083.92
FY 2003	Substance Abuse Services Out-Patient	\$600	\$200.00
FY 03 Total		3,428,573	

CFSA purchases these services for a number of reasons. First, the system has historically not provided some of these services through other means in a timely way. Second, some of the services are not available within the Medicaid system, or have not been in the past. This issue was evident in several examples in the recent Quality Services Review of a sample of CFSA cases, which suggested the lack of available DC Medicaid vendors to provide needed services such as dental and vision exams. In addition, some providers of specialty services do not accept DC Medicaid although the services are necessary to the child's well being. Third, the difficulties mentioned earlier in prompt transfer of children from managed care to FFS Medicaid might lead to CFSA payments for some services. Fourth, judges in the Family Court may in some cases order specific services or specific providers to be paid whether or not they are Medicaid-eligible or have contracts with CFSA. Finally, some of the payments may be for children who are not Medicaid-eligible, such as children in "third party" cases where a relative has custody of the child but CFSA has responsibility for supervising the case.

Specialized Foster Care

CFSA also purchases health-related services for children in foster care through its contracts with local child placement agencies that serve children with special physical or behavioral health needs. The providers who serve medically fragile children, who have chronic physical health needs, place the children in homes with specially trained foster parents who ensure that they receive the special services they need for daily living, such as the use of special medical equipment for breathing, eating or for mobility, and periodic care from medical professionals.

CFSA also provides behavioral health supports to children through its system of therapeutic foster care services. The agency contracts with private licensed child placement agencies to provide these children with intensive behavioral health services from a range of clinical professional staff and consultants. Therapeutic foster care is designed to be a short- or medium-term placement option during which children receive intensive behavioral health treatment such as individual therapy, group therapy, and prescribed psychotropic medication from professionals associated with the therapeutic foster care agency, while living in homes organized as therapeutic environments.

CFSA recently issued a Request for Proposal for Family-Based Foster Care Services in which these two types of care are combined in one service called specialized foster care. This action is the first step toward creation of a continuum of foster care services designed to meet a diverse range of children's needs for health and behavioral health care and other social supports. CFSA expects that a successful contractor will be prepared to address the health and behavioral health care needs of children referred for specialized care, and to utilize Medicaid-reimbursable providers whenever possible for supplementary health and behavioral health services not offered by the Contractor. Contractors are expected to enroll children with the Medicaid-reimbursable DMH Core Service Agencies and sub-specialty provider agencies in order that community-based behavioral health services remain available to children after they have left foster care and moved to permanent family settings. Contractors may purchase other needed services when providers who accept Medicaid are not available; these services will be reimbursed by local dollars. CFSA also expects Contractors to ensure that services delivered by the DMH and other community-based service networks are provided in response to assessed needs and are offered in an integrated and coordinated manner.

VI. Health Care for Foster Children in the District: Medical Resources and Services Beyond CFSA

The District of Columbia utilizes multiple funding resources through which medical services for children in the custody of CFSA are purchased. Children access and receive medical and mental health care services throughout the tri-metropolitan area (District of Columbia, Maryland and Virginia).

District funds for medical care for CFSA foster care youth, identified in this assessment, include the following additional resources:

1. Medical Assistance Administration (MAA)
 - a) Managed Care Organizations (MCO)
 - b) Fee for Service Providers
 - c) Health Services for Children with Special Needs (HSCSN)
2. DMH (DMH)

A. District of Columbia Medical Assistance Administration (MAA)

Managed Care Organizations

Managed Care Organizations (MCO) are establishments funded by federal and state government (including the District of Columbia) Medicaid that offer medical assistance to individuals and families with low income and resources. Medicaid services are offered through MCOs, which operate under a 1915 waiver. MCOs provide medical and mental health services to Medicaid clients. Medicaid typically pays a monthly fee for each Medicaid client enrolled in an MCO and/or Prepaid Mental Health Plan (PMHP). Each plan is responsible for all health care services specified in the contract for Medicaid clients enrolled in that plan. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits. The plan must specify services, which require prior authorization and the conditions for authorization.

The client's Medicaid Identification Card states the name of each plan in which he or she is enrolled. Clients enrolled in a MCO and/or a PMHP must receive all services covered by each plan through that plan. The provider obtains payment from the plan. Typically, each plan requires that a provider be affiliated and follow its coverage and authorization requirements. All questions concerning services covered by and payment from a MCO or PMHP must be directed to the appropriate plan.

The five MCOs operating in the District of Columbia are:

- ∞ Health Right;
- ∞ Chartered Health;
- ∞ Amerigroup;
- ∞ Advantage; and
- ∞ Health Services for Children with Special Needs.

Some of the services offered include: inpatient hospitalization, nursing facility, intermediate care facility for the mentally retarded, outpatient services, physician services, family planning, dental services, prescription drug, home health services, vision care services, transportation services, mental health/substance abuse and hospice.

Fee For Service Medicaid (FFS)

According to the Centers for Medicare and Medicaid services, Medicaid is the largest source of funding for medical and health related services for people with limited income. FFS Medicaid program clients receive covered services from any Medicaid provider. The provider must follow Medicaid coverage and prior authorization requirements. The provider submits the claim to and obtains payment from Medicaid. This type of Medicaid encompasses the same array of services provided in the MCO. However, the key advantage in this type of Medicaid for foster care youth is the ability to access services without a referral at any location with any participating Medicaid provider. Because our population is quite mobile, this form of Medicaid allows for system access regardless of placement change.

Health Services for Children with Special Needs

HSCSN is a Medicaid funded special program that allows for broader service delivery. It operates under a capitated payment system and a negotiated fee schedule for providers. We highlighted this MCO because of the specialized population they serve.

Medicaid benefits are available and enhanced benefits are offered in this model which include: individual plans of treatment, care management services, respite care, van transportation and taxi vouchers, feeding and nutritional programs, medical supplies and equipment, dental services, and physical, occupational, and speech therapy consistent with habilitative and rehabilitative needs.

Participation is voluntary and open to all SSI recipients residing in the District of Columbia who are 0-22 years of age. Children who are eligible for Medicare benefits with services related to transplants are excluded.

According to MAA, in FY 03 CFSA enrolled 114 foster care youth into the HSCSN program. This program is valuable to our children and foster parents by providing family centered care, medical case management and service coordination. Foster parents no longer have to search for specialty medical providers or navigate the health care system alone for this special needs population. This program provides a health telephone link to an on call representative to assist members during non-business hours.

B. Mental/Behavioral Health Services

Over the last two decades, there has been a sixty percent (60%) increase in the number of children entering the foster care system nationally⁸. The emerging research suggests that the increase is due to several factors, including the growing number of neglect cases resulting from parental drug and alcohol abuse and to the impact of poverty, homelessness, AIDS and domestic violence on at-risk families. Many of these factors, such as poverty and homelessness, are also risk factors for mental health problems in children and families and, of course, abuse and neglect place children at high risk for emotional disorders. Results of studies profiling the mental health status of children involved in child welfare indicate that children in foster care are three to ten times more likely to have a mental health problem than children on AFDC. Children in foster care are more likely to suffer from depression, anxiety disorder, ADHD, conduct disorder, bipolar disorder, and oppositional defiant disorder⁹. Often, the trauma of separation and multiple placements and transitions once children are involved in child welfare aggravates mental health problems in children and families.

⁸ According to a 2001 California Institute for Mental Health publication titled "Evidence-Based Practices in Mental Health for Foster Youth".

⁹ According to a 2001 California Institute for Mental Health publication titled "Evidence-Based Practices in Mental Health for Foster Youth".

Currently, the District of Columbia does not have a sufficient supply of board certified comprehensive service provider agencies capable of meeting all the mental health needs of children and families involved in child welfare.

Historically, the District's mental health system particularly for children, youth and their families has not been organized and resourced to meet these needs. The system was in Receivership for over 5 years, from 1997 to 2002. When the District began taking back control of its mental health system in 2001, the newly created DMH (DMH) began building and arranging comprehensive array of mental health and other services into a network of services that coordinate and work together to meet the multiple needs of children and adolescents with a "system of care" for children, youth and their families. The goal of this widely praised structural approach is for the overall human services delivery system to come together through systems integration, greater involvement of families (and surrogate families), greater cultural competence and improved clinical practice to foster resiliency for families (including surrogate families) and youth. It is also important to note that the "systems of care" relies both on well-organized, thoughtful systems and the delivery of effective clinical treatment based on evidence based or promising practice methods.

As of March 2003, four core service agency (CSA) providers were certified by DMH with some history of providing mental health services to children. According to the March 2003 Baseline Report on Children and Youth; 999¹⁰ children were receiving mental health services from four different agencies. The number of children served by these four providers is illustrated in Table 9 below:

Table 9: Children Served by CSA as of March 2003

CSA	Ages 0-9	Ages 10-13	Ages 14+	Total
Community Connections	11	12	20	43
Hillcrest Children's Center	11	48	39	98
DC Public CSA	143	171	134	448
Center for Mental Health Inc.	175	145	90	410
Total	340	376	283	999

As of August 2003, DMH reports that over 2000 children and youth were enrolled and receiving services through its certified provider network. Additional providers have been certified to provide services to children: Firhankra Place, First Home Care, Optimum, and Universal Healthcare. Eleven additional providers are in the pipeline to become certified providers of mental health services for youth.

In addition, CFSA has increased the referral and use of the Assessment Center through DMH (formerly Youth Forensics). According to DMH staff, the demand for assessments has increased steadily over the last two years. Over the past year alone (FY '03 compared to FY '02), the demand for DMH screenings and evaluations has increased by 22%; the two year increase in demand ('01 compared to '03) evidenced a 35% rise in referrals. In FY '03 the Assessment

¹⁰ We do not know how many of these youth are/were in the custody of CFSA. FY 2003 data was utilized, as data on youth served in the format that would be useful for this report was not available.

Center provided evaluations (all court ordered) of 352 CFSA youth and families: 133 adults and 219 youth for a monthly average of 29 assessments.

Despite a concerted effort by DMH to reduce wait times, the wait time for either a psychiatric or psychological assessment remains at 30 – 45 days. It appears that as the length of time for youth and their families to be seen decreased, the number of referrals for evaluations increased. Even though DMH has worked diligently over the past year to make improvements in this system, this increased demand has continued the delays in screening and assessing the mental health problems of children under the care of CFSA. The waits for appropriate services and treatment further aggravates their problems and jeopardizes their placement in permanent and loving homes.

It is important to note that a number of providers have experience in serving certain sub-populations, such as infants and young children, older adolescents, children with dual diagnoses (emotional disorders and developmental disabilities), or adolescents with co-occurring substance addictions and mental health problems, or in providing certain types of services, such as therapeutic foster care, in-home services, or behavioral management skills training.

The challenge for the District is to organize a culturally and clinically competent network of providers that builds on the strengths of the provider community. The District is committed to developing a broad, flexible array of mental health services and supports for children and families involved in the child welfare system. While some providers serve various sub-populations, there remains a need for services that show evidence or strong promise of effectiveness in promoting the safety, stability, permanency and well being of children under CFSA's care.

The District believes that a coordinated system of certified, evidence-based and promising practice mental health providers, will over time, result in several opportunities/benefits, which include:

- ∞ Integrating previously parallel systems (DMH MHRS providers and CFSA contractors) for mental health services for children, adolescents and families;
- ∞ A single consistent standard for oversight and delivery of publicly funded mental health services;
- ∞ Increased capacity of DMH certified mental health providers who have expertise in serving children, adolescents and families;
- ∞ Allowing the District to maximize its use of Medicaid funding for mental health services, which will increase dollars available for mental health services for children by drawing on federal Medicaid matching monies; and
- ∞ Reducing the need to spend local dollars on mental health services.

VII. Findings: Strengths and Areas in Need of Improvement in the Health Care System for Foster Children in the District

Information included in the quality service review (QSR) the Needs Assessment focus groups, in addition to our other work has facilitated the identification of strengths and areas where more work is still needed. The QSR process included the random selection of forty case records for further examination by a team reviewer. These cases have helped us to identify some of the areas where we are doing well and others where improvements are needed. Cases reviewed in the QSR process give insight into how the District is meeting the safety, permanency and well-being needs of some of our most vulnerable children. The ability to meet the physical and mental health needs of children in foster care is included as an indicator under the outcome of wellbeing.

Whereas the QSR brought the perspective from those involved with the case, the Needs Assessment focus groups provided more generalized thoughts about the strengths and areas in need of improvement. Respondents in the focus groups stated that the bureaucracy of the referral process, the lack of quality mental health services and difficulties in accessing medical services all hindered the ability of children and families to obtain needed physical health, including dental services, and mental health services. The focus groups did acknowledge that CFSA, as a whole, has made many positive changes but respondents identified several areas that still caused frustration and confusion when working to get services.

A. How Children and Families Experience the Program

Children and families in the District have very different experiences with the health/mental health services in the District. The review of the forty case stories in the quality service review (QSR) show that children and families involved with CFSA receive a wide range of services. Those areas that the QSR identified as strengths are: 1) the majority of children are in safe and stable placements, 2) children are placed with committed, effective caregivers who are advocates for their care, 3) all but one of the cases had an assigned caseworker, 4) children and families are receiving many services and supports and 5) there is a greater recognition of the importance of maintaining family connections. Those areas identified as needing improvement are: 1) assessment and case planning, 2) achieving permanency for children 3) adoption practices 4) clarification of case management responsibility, 5) maintaining case histories, and 6) health and mental health services.

The particular areas in the health/mental health are:

1. "The large number of children in the sample were receiving psychotropic medication with little evidence of systemic CFSA oversight."
2. "Access to dental care and some non-emergent medical care was problematic in some cases due to Medicaid issues or delays through DC Kids"
3. "The relative lack of substance abuse treatment to meet the level of need."

In addition to the QSR report, the Needs Assessment focus groups echoed many of the same concerns. Foster parents reported difficulties in accessing medical and dental services. ACC and CFSA workers felt that DC KIDS slows service delivery down, creates a backlog and does not have the capacity to meet the needs of the children and families we serve. Another issue that was brought up in both the Needs Assessment and the QSR are specific to Medicaid.

Respondents in the focus groups stated that there is a lack of quality service providers who accept DC Medicaid and for those children placed in Maryland, finding a provider who will accept DC Medicaid is even more difficult. The case stories in the QSR give specific examples of children who are experiencing difficulty in getting services. Some examples are:

1. Although children may have a Medicaid number, they do not have the Medicaid card and therefore providers will not provide treatment or services.
2. One caregiver lost benefits even though she was still caring for the children
3. A grandmother and her granddaughter cannot get Medicaid coverage because her income is too high because she receives a stipend from CFSA.

However, examination of the cases reviewed show there are a variety of services that have been identified and provided to ensure that the needs of children in the system are being met. These services range from medical assessment and referrals, psychological or psychiatric evaluations to identify needs individual or group therapies or medication to manage condition or change behavior. In those cases where medical care is mentioned, the range of services encompasses managing chronic asthma to the need for braces. It appears that families and children are receiving services, but there does seem to be a lack of coordination in many of these cases. The lack of coordination can be seen specifically when a caregiver reports that two agencies are providing therapy that is duplicative, another example is evidenced when in another case a child who was placed out of state for five years received little to no services - dental, psychological or foster care payments. Similarly, there does not seem to be any standard way that a child's physical or mental health care is coordinated. In some cases it is the foster parent or kinship caregiver who coordinates everything, in other cases it is the CFSA worker, still in other instances it is a worker at a private agency. Children are still able to receive services and get the needed treatment, but because some children have a worker or advocate who is able to navigate the system they may receive services sooner or more regularly than those who do not. There are several case examples of both of these situations.

- ∞ *Reviewers in one case reports that the foster mother ensures that the foster mother ensures that the child receives regular health check-ups and is a strong advocate for the child's mental health needs.*
- ∞ *Another case story states that a private agency social worker coordinates educational services, mental/physical health services, and has an up to date record of vaccinations.*
- ∞ *Another case story states that the service team is meeting the medical and psychological needs of the child*
- ∞ *A child who was placed in a home out of state had great difficulties in obtaining medical services, counseling and foster care payments*
- ∞ *A mother who was experiencing difficulty contacted a community organization on her own in order to get the services that she needed*
- ∞ *Out of date medical records, IEPs, family assessments are hindering service delivery to children and families.*

It is our intent to use the QSR reviews, the Needs Assessment focus groups as well as this Health Assessment as tools to help us improve our health/mental health services to the children and families that we serve. We recognize that children in our care are receiving uneven services and it is our goal to work with other District agencies to ensure that the children we serve receive

timely, appropriate and adequate services. It is also our goal to work through the issues relating to Medicaid.

B. Overall System Strengths

This review revealed many strengths in the health service delivery system for foster care youth. These strengths provide a firm foundation for next steps by CFSA and the District of Columbia. In identifying strengths, we have sought to use the framework developed above regarding the key characteristics of a strong health care system for foster children and adolescents. Major strengths that have been identified include:

1. Major investments in services by a range of District agencies, which appear to have had the effect of addressing historic gaps in service at least to some extent. There are currently several funding sources and mechanisms that are employed for health service delivery to children in the District. Funding sources include CFSA local dollars and Medicaid fee-for-service. Services are provided through the DC KIDS program, specialized foster care, DMH, and community providers. Some of these services were designed specifically to fill gaps – e.g., specialized foster care. In a review of the QSR case studies, the range of services is also seen. Children and families are receiving group and individual therapy, special education services and substance abuse treatment, to name a few.
2. A substantial array of community health care providers through which youth and families may access needed and required services. Current community resources include eleven core service providers including Hillcrest Children's Center and Northwest Family Center. In addition there are nine Medicaid providers, 2 contracted agencies and 75 other non-contracted agencies that serve children in the foster care system. CFSA has had long-standing relationships with many of the agencies and depends upon them to provide individual and family counseling, psychological assessment and evaluation, medication management and psychiatric evaluations.
3. Considerable investment in highly qualified and specialized staff with experience in child abuse/ neglect located at the Freddie Mac Foundation Child and Adolescent Protection Center at CNMC.
 - ∞ DC KIDS/ CNMC - According to the CSSP study, CNMC has a recognized track record of providing primary and subspecialty care to children in the District of Columbia and every treating physician has completed an accredited pediatric medical program.
 - ∞ OCP – CFSA has made a substantial investment in bringing on board trained clinicians in the medical and mental health disciplines.
4. Major investments and reforms directed towards improving coordination and continuity in the system.
 - ∞ The development of the OCP to provide oversight of the system and clinical consultation to staff in negotiating the health care delivery system.
 - ∞ Investment in DC Kids in an effort to provide a single point for screening and continuity/ coordination thereafter.

- ∞ The development of a strong collaboration with the District's DMH.
 - ∞ The provision of services to high-risk drug/alcohol exposed infants and their mothers through a Memorandum of Understanding with the Alcohol Prevention and Recovery Administration (APRA) and the Department of Health.
 - ∞ A Memorandum of Agreement between CFSA, the Department of Human Services, Mental Retardation and Developmental Disabilities Administration for coordinated service provision to children and youth with mental retardation who are residents of the District of Columbia.
 - ∞ Collaboration with DMH around DC CINGS (a Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded for the development of a system of care for children who are at-risk of institutionalized residential care).
5. Work in progress to improve information collection and tracking
- ∞ The existence of a reliable method to track the timeline requirements in the Implementation Plan.
 - ◇ FACES Medical Screen changes have significantly streamlined the medical screens and provide methods to track medical prescreening evaluations and comprehensive EPSDT examinations;
 - ◇ Data from DC Kids/CNMC is uploaded into FACES nightly (to begin shortly);
 - ◇ Appointments made at DC Kids/CNMC populate into the FACES appointment log with information regarding the appointment type (dental, vision, subspecialty, EPSDT) and indicates the status of the appointment – a scheduled or completed evaluation;
 - ◇ Core laboratory studies and test results as required in the comprehensive examination (EPSDT) also populate into the medical screens as do immunizations administered;
 - ◇ The new screens will specify whether the medical condition was observed by the social worker or diagnosed by a medical professional;
 - ◇ The redesign of the medical screens satisfies the Federal requirement for FACES to be able to select and report the adoptive children's medical conditions which are diagnosed by professionals.
 - ∞ Collaboration between MAA, HSCSN and DMH to share financial and clinical data has begun in an effort to eliminate duplication of services and enhance continuity of care.
6. Reduced social worker caseloads and other improvements in practice that make possible the needed social worker role in supporting continuity of health care

C. Overall System Weaknesses/ Areas for Further Improvement

System complexity leading to lack of clarity

While the breadth of the District's array of services and funding sources are important strengths, the system is hard for participants to understand, contrary to the criterion of uniform and seamless care. This can lead to services not being accessed because participants don't know they're available, and it can lead to a lack of oversight of quality and timeliness when services are provided through multiple mechanisms.

Gaps in coordination of services, including incomplete enrollment in DC KIDS

The evidence reviewed above suggests a number of challenges in coordinating care for foster children in the District. The QSR case reviews suggest that a variety of individuals may take the initiative to coordinate care (social worker, foster parent) but that there is not a consistent way to ensure coordination. One of the obstacles to this role's being carried out by DC KIDS is the ambiguity about whether DC KIDS' role is primarily to be a coordinator or a service provider. A related obstacle is that not all foster children are enrolled with DC KIDS, in part because social workers and foster parents may see it as a service provider rather than the point of coordination. That is, the vision as expressed by CFSA leadership indicates that DC KIDS would be a tracker and coordinator of care services for all children enrolled in the program, with the limited exception of children enrolled in HSCSN, who remain enrolled in that specialized MCO. However, in practice, currently all youth in CFSA are not enrolled with the DC Kids program. If the caretaker or social worker elects not to enroll the child into the DC Kids program, services are coordinated and rendered independently, thus creating a multi-faceted and complex system for care coordination. We do not know yet all the reasons that might lead to this choice – whether geographical barriers or other access barriers affect it. One consequence is that medical services provided to youth external to the DC KIDS program are not monitored under guidelines currently set forth in the CFSA DC KIDS contract.

Challenges to Continuity of Services

As noted earlier, continuity of care is a major issue for all child welfare systems. As illustrated by the Jacksonville and PACE systems, model programs have often focused on continuity during the time in care; an additional, and potentially more difficult issue, is continuity with health care prior to removal from the home and into foster care. Both continuity with prior care and continuity while in care require more attention in the District.

DC KIDS is intended to assure the second, continuity while in care: it is required to coordinate all services based upon the treatment plans generated at the time assessments are completed. However, at this point, in part because of the complexity of the system, not all children are in DC KIDS and follow-up for those who are in it is inconsistent.

As for the first, continuity with prior care, the DC KIDS mechanism is not at this point designed to provide that; a child's enrollment in the DC KIDS Program disconnects them from their prior

primary care provider, even though in theory, because DC KIDS is a FFS Medicaid program, they could often be served by that provider.

Inconsistent Availability of Appropriate Health Care Services Within Time Limits

A number of sources, including the QSR reports as well as focus groups and interviews suggest that certain specific services are not consistently available in a timely manner. Key examples include dental, vision and behavioral health. In addition to District-wide gaps, there are insufficient providers for these services within the DC KIDS provider network to assure timely, safe and efficient access to necessary services. The resources for behavioral health are particularly problematic, in that the lack of community based mental health resources adversely impacts inpatient stays and discharge planning; as well as timely referrals to other recommended outpatient mental health services. In addition, because of the ambiguity regarding care provision vs. care coordination, it appears from this initial analysis that DC Kids under utilizes the available network of service providers, further impacting the timely provision of services of services of children.

Medicaid enrollment issues

One specific issue related to Medicaid enrollment is that there appear to be a number of points in the process where Medicaid enrollment and/or change in Medicaid status from MCO to fee-for-service may be delayed. These issues come up in the QSR and also in analysis of the DC Kids data. In addition, the QSR's suggest further issues with Medicaid eligibility (which appear to relate to children who are not committed to CFSA) and with access to Medicaid cards.

Information Management, Monitoring and Accountability

A number of issues relating to the flow of medical information as well as monitoring and accountability remain challenging. For example, while it ought to be possible to identify a child's past primary care provider at the initial screening if a child has been enrolled in MCO Medicaid in fact little or no medical information is available at the time of the initial medical screen. Children in essence are medically screened with no knowledge of any past medical history except for what little may be relayed by the accompanying social worker. Oftentimes investigators are not always successful in obtaining medical information during the time of a removal. Clearly this is an area for further development.

While the medical information system that will identify that MCO and primary care provider is available at CNMC, this information is neither tracked nor recorded for CFSA children. According to the Medicaid Assistance Administration, 60% of children are enrolled into Medicaid regardless of plan; however, we were unable to glean the percentage of CFSA children that are enrolled into an MCO or FFS plan at the time of entry into care. We expect that a large percentage of children entering care were either eligible or enrolled in Medicaid. It is important to note the Implementation Plan requirement that children be screened within 24 hours of entering the department's custody, is more rigorous as than the other child welfare systems surveyed. An unintended complication is the difficulty of having substantive medical and behavioral health information available when the child is initially evaluated.

D. Status of Implementation Plan Targets

Medical Screens within 24 hours of entering the Department's custody

IP Strategy Requirements: *Medical Screens within 24 hours of entering the Department's custody.*

IP Outcome Requirement: *By December 31st, 2003, 60% of children in foster care will have a health screening prior to placement.*

Based on a first-ever data match, 73% of those children who entered care in FY03 and whom we successfully matched with health care provider information on the first try received their medical screening within 24-48 hours. The data are still being double-checked and further analyzed, since we have only just completed the match.

We were able to match CFSA FACES data on all initial and re-entry removals during FY03 with data on medical screens from DC KIDS and from St. Ann's Infant and Maternity Home. St. Ann's Infant and Maternity Home operated during FY03 as a diagnostic and emergency shelter for children who were removed after hours and were not able to successfully be matched to a foster home. Part of the service agreement was for St. Ann's Infant and Maternity Home to complete a medical screen for these children in a manner that reduced the trauma and waiting periods usually likely in the emergency room during off hours when more critical emergencies typically occur. St. Ann's Infant and Maternity Home served 256 children during FY03 for brief periods of time until they were successfully matched to a foster home. It is of note that most of the children were placed in DC Foster homes within a relatively short period of time.

Table 9 reflects a 64% match rate between data received from DC KIDS matched against CFSA and St. Ann's Infant and Maternity Home data. Out of the matches, 73% (398) were screened within 24 hours of home removal. We are currently reviewing the 307 children with no data match to determine whether they are due to misspellings in names or minor inaccuracies in other identifying data, or children not reflected in either the St. Ann's Infant and Maternity Home or DC KIDS database. For example, many placements are to acute care hospitals or residential placements¹¹ that involve their own internal medical screening. This will require further review and investigation.

The medical screens provided at St. Ann's Infant and Maternity Home were no later than 48 hours after placement. That is, a child who arrived Saturday evening may not be medically screened until Monday morning when the contracted medical personnel were available. However, as indicated below, the medical screens performed by St. Ann's Infant and Maternity Home were more rigorous and mirrored the EPSDT in terms of the components and the depth of the evaluation. We do not know as of this writing how many of the children received the medical screen within 24 hours, we do know that all 256 received the

¹¹ According to CFSA documentation within OCP, there were # of children who entered Acute care # children who entered Residential Care.

medical screen within 48 hours. We also know that these children also received the comprehensive medical evaluation way within the IP 30-day requirement.

**TABLE 11: Medical Screening Information for
Children With Home Removals in FY 2003**

Total children removed from home in FY 2003 (from FACES)	849	
<i>Initial home removals</i>	682	
Re-entries	167	
Children with home removals in FY 03 with a DC KIDS or St. Ann's Infant and Maternity Home data match	542	
Medical screening completed within 24 Hours of home removal	398	
Medical screening completed within one week of home removal	21	
Medical screening done within 30 days of home removal	38	
Subtotal: Medical screenings done within 30 days of home removal	457	
Medical screening done more than 30 days after home removal	85	
Number of children removed from home in FY 2003 with no DC KIDS or St. Ann's Infant and Maternity Home data match	307	

Further preliminary evidence of overall compliance with the expectation of routine and prompt medical screening is the fact that the total number of medical screens completed by DC KIDS in FY 03 is approximately consistent with the total number of replacements reported by FACES in the same fiscal year. This data will have to be further refined to provide detailed information on timeliness; CFSA was unable to do a data match within the time constraints of this report.

TABLE 12:

Initial Placements, Re-entries, and Replacements of Children in FY 2003

Initial Placements	Children	Families Involved
Annually	682	408
Monthly	56	34
Weekly	13	8
Daily	2	1

Re-entries (Children who went home and then returned to care)	Children	Families Involved
Annually	167	108
Monthly	14	9
Weekly	3	2
Daily	0.46	0.30

**TABLE 13:
Replacements**

Replacements (Change of Placement for Children already in Foster Care)	Children	Families (Cases) Involved
Annually	1200	996
Monthly	100	83
Weekly	23	19
Daily	3.28	2.73

2. Full medical and dental evaluations within 30 days of entering custody.

IP Strategy Requirements: *A full medical and dental examination within 30 days of entering physical custody.*

IP Outcome Requirements: *By December 31, 2003, 60% of children in foster care will receive a full medical and dental evaluation within 30 days of placement.*

In FY03 St. Ann's Infant and Maternity Home conducted 256 full EPSDT assessments on children who entered care. We are currently analyzing the data from DC KIDS and matching it to our data to determine how many children received EPSDT's in FY03. Overall, the numbers and other information suggest to us that many children are receiving the physical examination portion of the EPSDT through DC Kids, but we are somewhat concerned regarding behavioral, dental, and vision evaluations.

We are also currently reviewing the process for scheduling the EPSDT to create greater consistency, timeliness, and clarity for monitoring. The expectation of CFSA is that at the time of the prescreening evaluation an appointment will be scheduled for the comprehensive physical (EPSDT.) For a myriad of reasons, this is not routinely done. If the EPSDT is not scheduled at the time of the initial screening (for example, because there is no identified placement for the child), it is then the responsibility of the social worker assigned the case to submit a referral requesting an appointment for the comprehensive physical to Health Specialist in the OCP . Because CFSA has 30 days in which to complete an investigation, the assigned social worker may be at the point of transferring the case to an ongoing social worker when the physical examination is scheduled. Scheduling may be complex since there are separate locations for the dental, vision and behavioral evaluations.

Other factors that impact the completion of the comprehensive physical (EPSDT) within 30 days of placement include:

- ∞ The actual locations of the placement given that approximately 50% of children in care reside outside of the District of Columbia.
- ∞ Enrollment gaps, as described earlier.
- ∞ An MCO PCP who is unknown and/or inaccessible to the family.
- ∞ The inability to access services with only a Medicaid number but no card.
- ∞ The lack of a sufficient number of DC Medicaid providers for pediatric, dental, vision and behavioral health services in the surrounding jurisdictions.

Currently, a number of strategies are in place to improve completion of the total EPSDT package:

- ∞ Regularly scheduled meetings between OCP and DC KIDS/CNMC medical management are effectuating change in their practices such as scheduling.
- ∞ Data collection and tracking are being streamlined through the revised Medical screens.
- ∞ On-going collaboration with other District agencies will assist to identify Medicaid providers in DC and other jurisdictions who make their services available to CFSA children.
- ∞ As we focus on safety, permanency and wellbeing, CFSA is working to increase social workers' awareness of the very real medical, developmental, and behavioral health needs of the children and of the availability of the OCP to support social workers.
- ∞ We are also working to improve information exchange with foster parents, for example through the new policy on Relationships with Resource Parents. In consultation with foster parents we will develop systems of information exchange – from CFSA to the family and from the family to CFAs so that each child will have a documented medical history that will accompany him/her wherever they may go.

3. Professional Evaluations of Children Within 30 Days of Replacement

IP Strategy Requirement: *A thorough professional evaluation of his or her needs within 30 days of replacement.*

IP Outcome Requirement: *By December 31, 2003, CFSA will ensure that children in its custody whose placements are disrupted are provided with a thorough, professional evaluation to determine their service and replacement needs within 30 days of replacements in 50% of replacements.*

CFSA provides thorough professional evaluations in cases of replacement in a number of different ways, including through evaluations by social workers who assess the child's adjustment to the new placement and who identify any additional evaluation or service needs. Evaluations are also done through clinical staffings, which can occur at the time of replacement or shortly thereafter. Further, we believe implementation of the Facilitated Family Team Meetings which includes the family, the child, health care providers when appropriate, as well as internal and external formal and informal supports will also provide the professional evaluation set forth herein.

Currently, staffings occur to supplement the social worker's professional judgment on a number of disrupted placements, including pre-adoptive disruptions, placement disruptions and emergency re-placements. At this point, we do not know how complete is the coverage of these disruptions through staffings. In 2003 there were 1200 replacements. As of this writing we do not know how many of these replacements resulted from disruptions vs. a planned placement move. OCP estimates that staffings have occurred for 25% of the total re-placements that took place in 2003.

As indicated above, CFSA has made a commitment to address major issues around service provision, service coordination, team decision making and professional assessment of children who come into care as well as children who for many reasons face placement changes. The mechanism that the agency has chosen to effectively do this generally follows the Family to Family Model developed by Annie E. Casey. The Facilitated Family Team Meetings (FFTM) will be used on every removal and every placement change. The variance on the model may center around the availability and presence of a strong internal clinical consultation support that can be part of a multidisciplinary team as well as the degree of community involvement and family participation. The agency intends to build on the lessons learned from other jurisdictions as well as locally in models of FFTM's that are successful in bringing the community as family into the process.

VIII. Action Steps

The IP requirements for the action steps within this assessment is stated as follows:

CFSA will conduct an assessment of the capacity to provide health screening and physical and behavioral health evaluations for children in foster care, taking into account the DC KIDS evaluation produced by the Court Monitor, From this Assessment, CFSA will develop a plan of action and will propose provisions to the plaintiffs and the Court Monitor for incorporation into the Implementation Plan to assure that all children (1) receive a medical screening within 24 hours of entering the Departments custody; (2) a full medical and dental examination within 30 days of entering custody; and (3) a thorough professional evaluation of his or her needs within 30 days of re-placement.

A. Medical Screen within 24 hours of entering the Departments Custody

IP Strategy Requirement: *Children receive a medical screening within 24 hours of entering the Department's custody.*

IP Outcome Requirement: *Children in foster care will have a health screening prior to placement. (June 30th, 2003 – 50%; December 31st, 2003- 60%; December 31, 2004 – 75%; December 31, 2005 – 90%).*

1. CFSA will improve data tracking of the timeframe from child's entry into care and the initial medical screen as well as monitoring FACES and DC

KIDS on a monthly basis to ensure increased compliance. Ensuring that the medical screens within FACES are appropriately and accurately capturing this information will accomplish this IP requirement. CFSA will continue with the regularly scheduled daily data exchange with DC KIDS.

2. CFSA will review current DC Kids contract and clarify in writing with them the specific requirements of screening by March 1st, 2004. CFSA has already instituted monthly contract monitoring and data review with DC KIDS and CFSA that is chaired by the OCP Administrator (pediatric physician) or designee.

B. Full Medical and Dental Evaluation within 30 days of entering care

IP Strategy Requirement: *Children receive a full medical and dental examination within 30 days of entering physical custody.*

IP Outcome Requirement: *Children in foster care will receive a full medical and dental evaluation within 30 days of placement. (September 30th, 2003 – 50%; December 31st, 2003-60%; December 31, 2004 – 75%; December 31, 2005 – 90%)*

1. Clarify DC KIDS Provider and Coordinator Role/s The role of DC KIDS should be clarified as a coordinator of care. As such the DC KIDS program would include but not be limited to the following activities:
 - ∞ Service network development
 - ∞ Coordinator of Care
 - ∞ Quality Assurance i.e. assure that network providers are appropriately credential and licensed;
 - ∞ Appointment scheduling;
 - ∞ Data information gathering and tracking;
 - ∞ Report writing and submission;
 - ∞ Information and referral resource; and
 - ∞ Service linkage
2. Development of Policy and Procedures – Develop medical policy that define the target population for whom enrollment in the DC KIDS program will be mandatory. The target population will be all children entering care with the exception of children who meet the criteria for enrollment in HSCSN. These policy changes must be published, communicated and broadly disseminated throughout CFSA.
3. By March 30th, 2004 CFSA will gather and review data from MAA, DC KIDS and other sources on services provided to children that were paid by Medicaid through MCO and fee for service plans. This data will be useful in crafting a strategy of improved services to children who reside in other jurisdictions (Maryland and Virginia,) and who may have difficulty accessing DC Medicaid vendors in their respective communities.
4. The Agency is in the process of developing an automated data interface with CNMC (CNMC) of Washington, DC. The interface will allow FACES to maintain accurate medical information in the application. On a daily basis, CNMC will supply

FACES with a series of files containing medical information for all children in foster care who are in the DC Kids program. In addition to receiving current medical information, CNMC will also provide the patients medical history. The interface files will include patient primary care physician information, scheduled medical appointments, canceled appointments, emergency visits, the diagnosis or result of each appointment or visit, immunizations, allergies, medications, and tests. The interfaced medical information will provide workers with accurate and the most up to date information for the care of their clients. All medical information received from CNMC will be displayed in the screens located under the Health module in FACES. The Agency plans to begin implementation of this enhancement on January 21, 2004 this month.

C. Thorough Professional evaluation to determine service and re-placement needs within 30 days of re-placement

IP Strategy Requirement: *Children receive a thorough professional evaluation of his or her needs within 30 days of replacement.*

IP Outcome Requirement: *CFSA will ensure that children in its custody whose placements are disrupted are provided with a thorough professional evaluation to determine their service and re-placement needs within 30 days of re-placements. (December 31st, 2003- 50%; June 30th, 2004 – 60%; December 31st, 2004 – 70%; December 31, 2005 – 85%)*

Institute the Facilitated Family Team Meetings for removals by June 30th 2004 and for replacements by September 30th, 2004

Implement Family Based and Congregate Care contract reforms that will require improved service linkages to behavioral and mental health service providers such as the DMH Core Service Agencies.

IX. Concluding Thoughts

Beyond the specific action steps addressed through the Federal Court's Implementation Plan, CFSA also intends to explore with its District partners a number of broader issues regarding health and mental health care that are raised by this assessment.

1. Coordination and Communication with Child's MCO - The coordination of health care services is central to achieving the best clinical outcome for youth. This is particularly key when dealing with a highly vulnerable population such as foster care youth. CFSA intends to explore mechanisms that would facilitate the timely availability of information from the child's MCO.

2. Additional models of Service Coordination. CFSA, with other relevant District agencies should explore several different models of service coordination, looking at a variety of options for how the key functions should be divided between the public child welfare and health care agencies, external health care organizations, and other community-based resources.

3. Network Development – CFSA is excited by the opportunities for continued District-wide partnership to stimulate capacity building, particularly through mental health and behavioral health service reform. A helpful support to that partnership would be Congressional passage of the Omnibus Appropriation, which will make available resources to the DMH targeted to serving CFSA children. CFSA is also pursuing internal contract reform processes to improve services monitoring for therapeutic services, to expand the network of approved and qualified service providers, and to improve service linkage and coordination.

V. Appendices